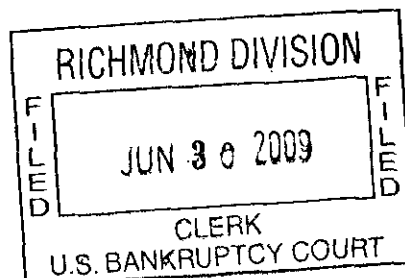


Gregg M. Galardi, Esq.
Ian S. Fredericks, Esq.
SKADDEN, ARPS, SLATE, MEAGHER &
FLOM, LLP
One Rodney Square
PO Box 636
Wilmington, Delaware 19899-0636
(302) 651-3000

Dion W. Hayes (VSB No. 34304)
Douglas M. Foley (VSB No. 34364)
MCGUIREWOODS LLP
One James Center
901 E. Cary Street
Richmond, Virginia 23219
(804) 775-1000

- and -

Chris L. Dickerson, Esq.
SKADDEN, ARPS, SLATE, MEAGHER &
FLOM, LLP
333 West Wacker Drive
Chicago, Illinois 60606
(312) 407-0700



Counsel to the Debtors and
Debtors in Possession

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

----- x
In re: : Chapter 11
: :
CIRCUIT CITY STORES, INC., : Case No. 08-35653 (KRH)
et al., : :
: :
Debtors. : Jointly Administered
CLAIM: 3995 *CASE: 08-35653*

GIBSON, THOMAS
66 ATHENS ST
SAN FRANCISCO, CA 94112

Clerk of the Bankruptcy Court
United States Bankruptcy Court
701 East Broad Street - Room 4000
Richmond, Virginia 23219

To whom it may concern,

I Thomas N. Nelson do hereby file a claim against Circuit City Stores Inc. Case No 08-35653 in the sum of \$250,000.00. for the purpose of compensation for injuries I received while working at the San Mateo store #0232 as a warehouse person. I am submitting date of injury reports as exhibit #1. I am also sending copies of the treating doctors report, MRI clinical findings and spinal findings from Kaiser Hospital as exhibit 2. I am also sending you workers compensation ~~reports~~ appeals boards stipulation.

I am also asking for compensation from Circuit City for all the labor violations used on me, such as no break, no lunch. Being told by new managers that they were sent to that store to terminate me. No light duty being made available to me.

I feel that I am only asking for what Circuit City owes me. I am asking for consideration of the money I can no longer earn also the pain I will live in for the rest of my life.

Sincerely
Thomas N. Nelson

State of California		Please complete in triplicate (Type 7 possible), mail two copies to:		OCHA Case No.	
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		c/o HELMSTROM MGMT SVCS, INC 333 CITY BLVD. WEST 9300 ORANGE, CA 92668		CONFIDENTIAL	
		Carrier Claim No. WC502-128465		<input type="checkbox"/> Fatality	
<p>NOTICE: California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident. OSHA requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported immediately by telephone or teletype to the nearest office of the California Division of Occupational Safety and Health.</p>					
EMPLOYER	1. FIRM NAME CIRCUIT CITY STORES, INC.		1A. POLICY NUMBER WC2-151-074398-012		DO NOT USE THIS COLUMN
	2. MAILING ADDRESS (Number and Street, City, Zip) 1880 SOUTH GRANT STREET SAN MATEO, CA 94402		2A. PHONE NUMBER (415) 578-1400		Class No.
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, Zip)		2B. LOCATION CODE 0232		Ownership
	4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, museum, hotel, etc. RETAIL		5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. 66-0493075		Industry
EMPLOYEE	6. TYPE OF EMPLOYER <input checked="" type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> SCHOOL DIST <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____				Occupation
	7. EMPLOYEE NAME GIBSON, THOMAS R		8. SOCIAL SECURITY NUMBER 547-58-2196		Sex
	9. HOME ADDRESS (Number and Street, City, Zip) 66 ATHENS STREET SAN FRANCISCO, CA 94112		10A. PHONE NUMBER (415) 584-7480		Age
	11. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		12. OCCUPATION (Regular job title - NO details, abbreviations or initials) WAREHOUSE WORK		13. DATE OF BIRTH (mm dd yy) 11/34/1963
INJURY OR ILLNESS	14. EMPLOYEE USUALLY WORKS Days per week: 5, per day: 8, total weekly hours: 40		14A. EMPLOYMENT STATUS (check applicable status at time of injury) <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Full time <input type="checkbox"/> Part-time <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal		14B. EMPLOYEE'S USUALLY WORKS Days per week: 5, per day: 8, total weekly hours: 40
	15. GROSS WAGES SALARY \$ 551.20 per WK		16. OTHER PAYMENTS NOT REPORTED AS WAGES SALARY (e.g., tips, travel, lodging, overtime, bonuses, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Weekly wage
	17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy) 05/05/1995		18. TIME INJURY ILLNESS OCCURRED 09:30 AM		19. TIME EMPLOYEE BEGAN WORK (mm dd yy) 06:00 AM
	20. DATE LAST WORKED (mm dd yy) 05/04/1995		21. DATE RETURNED TO WORK (mm dd yy) 05/05/1995		22. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy)
ILLNESS	23. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24. DATE LAST WORKED (mm dd yy) 05/04/1995		25. DATE RETURNED TO WORK (mm dd yy) 05/05/1995
	26. PAID FULL WAGES FOR DAY OF INJURY ON LAST DAY WORKED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		27. DATE OF EMPLOYER'S KNOWLEDGE OF INJURY ILLNESS (mm dd yy) 05/05/1995		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) 05/05/1995
	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED. MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendinitis of left elbow, back pain, etc. STRAIN TO THE RIGHT SHOULDER				
	30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City) 1880 SOUTH GRANT STREET SAN MATEO, CA 94402				
ILLNESS	31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop WAREHOUSE		32. OTHER WORKERS INVOLVED IN THIS EVENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Source
	33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN THE EVENT OR EXPOSURE OCCURRED, e.g., crane, welding torch, gas, tractor, material. BOXES OF PRODUCE				
	34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN THE EVENT OR EXPOSURE OCCURRED, e.g., building beams of metal frames, loading boxes onto truck UNLOADING THE TRUCK				
	35. HOW INJURY/ILLNESS OCCURRED, DETAILED SEQUENCE OF EVENTS, EXCEPT OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker slipped back to inspect work and slipped on scrap material. As he fell, he brushed against iron wall, and bumped right hand. USE SEPARATE SHEET IF NECESSARY. THE EMP. WAS UNLOADING THE TRUCK AND AS THE EMP. WAS PULLING A BOX DOWN HE INJURED HIS RIGHT SHOULDER.				
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, Zip) MARTINE MEDICAL CENTER 1261 EAST HILLSDALE BLVD. FOSTER CA 94404		37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, Zip)			
WITNESSES (NAME & PHONE #) WATSON, JOE (415) 578-1400					
Completed by (Type or Print) GRANT, TRAVIS		Signature <i>Travis Grant</i>		Date 06/31/1995	

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

04-0874-02

2 of 6

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS		Please complete in triplicate (Type if possible). Mail two copies to: CIRCUIT CITY STORES, INC. C/O HELMSMAN MGMT SVCS, INC. 333 CITY BLVD WEST #300 ORANGE, CA 92668		DWC-1 Carrier Claim No. WC602-163993		OSHA Case No. <input type="checkbox"/> Fatality	
NOTICE: California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury/illness, or death must be reported immediately by telephone or teletype to the nearest office of the California Division of Occupational Safety and Health.							
EMPLOYER	1. EMPLOYER'S NAME CIRCUIT CITY STORES, INC.			1A. POLICY NUMBER		DO NOT USE THIS COLUMN	
	2. MAILING ADDRESS (Number and Street, City, St.) 8150 MAYLAND DRIVE RICHMOND VA 23233			2A. PHONE NUMBER (415) 878-1400		Case No.	
	3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, St.)			2B. LOCATION CODE ABELL		Ownership	
	4. NATURE OF BUSINESS (e.g., painting contractor, wholesaler, grocery, carwash, bank, etc.) RETAIL			5. STATE UNEMPLOYMENT INSURANCE ACT NO. 54-0493875		Industry	
EMPLOYEE	6. TYPE OF EMPLOYER <input checked="" type="checkbox"/> PRIVATE <input type="checkbox"/> STATE <input type="checkbox"/> CITY <input type="checkbox"/> COUNTY <input type="checkbox"/> GOV. OR BUS. <input type="checkbox"/> OTHER GOVERNMENT - SPECIFY _____			7. DATE OF BIRTH (mm dd yy) 11/16/1943		Sex	
	7. EMPLOYEE NAME GIBSON, THOMAS H			8. SOCIAL SECURITY NUMBER 347-55-2198		Age	
	9. HOME ADDRESS (Number and Street, City, St.) 66 ATHENS STREET SAN FRANCISCO CA 94112			10A. PHONE NUMBER (415) 584-7450		Daily hours	
	11. SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE			12. DATE OF BIRTH (mm dd yy) 10/26/1987		Days per week	
INJURY OR ILLNESS	12. EMPLOYEE USUALLY WORKS Hours per day 8 Days per week 40			13. EMPLOYMENT STATUS (Check appropriate status, if more than one, check all that apply) <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary		14B. Show when glass cover of your policy was again covered	
	15. GROSS WAGES SALARY \$-572.20 per WK			16. OTHER PAYMENTS NOT REPORTED AS WAGES SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Weekly hours	
	17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy) 09/30/1995			18. TIME INJURY/ILLNESS OCCURRED _____ AM 12:00 PM _____		19. TIME EMPLOYEE BEGAN WORK (mm dd yy) _____ AM _____ PM	
	20. DATE LAST WORKED (mm dd yy) No Lost Time			21. DATE RETURNED TO WORK (mm dd yy)		22. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy)	
INJURY OR ILLNESS	23. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY/ILLNESS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) 12/27/1996		25. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) 12/27/1996	
	26. PAID FULL WAGES FOR DAY OF INJURY/ILLNESS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			27. DATE OF EMPLOYEE'S KNOWLEDGE OF INJURY/ILLNESS (mm dd yy) 12/27/1996		28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) 12/27/1996	
	29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED. MEDICAL DIAGNOSIS, if available, e.g., second degree burn on right arm, laceration of left arm, head penetrating PAIN IN LEFT ARM, SHOULDER AND ELBOW			30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City) 1880 SOUTH GRANT SAN MATEO, CA 94402		31. COUNTY SAN MATEO	
	32. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop WAREHOUSE			33. OTHER WORKERS INJURED IN THIS EVENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		34. ON EMPLOYER'S PREMISES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
INJURY OR ILLNESS	35. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN THE EVENT OR EXPOSURE OCCURRED, e.g., saw, knife, welding torch, farm tractor, etc. REPT MOTION			36. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN THE EVENT OR EXPOSURE OCCURRED, e.g., standing against metal frame, loading boxes on to truck WAREHOUSE WORKER		37. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap material. All the feet, he brushed against metal wall and burned right hand. USE SEPARATE SHEET IF NECESSARY. EMPLOYEE HAS ACCUMULATIVE TRAUMA FROM DOING REGULAR JOB DUTIES.	
	38. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, St.) DR. GIESSENDOERF, DR. 415-347-0500			39. PHONE NUMBER		40. SOURCE	
	41. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, St.)			42. PHONE NUMBER		43. EXTENT OF INJURY	
	44. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, St.)			45. PHONE NUMBER		46. EXTENT OF INJURY	
Completed by (Type & Print) ABELL, MELISSA Signature Melissa Abell Title CLAIMS ANALYST Date 03/21/1997							

FD-503 (REV. 6-82)

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01-087-2-00

3 of 6

JULY 16, 1996

CONFIDENTIAL

INT
This will acknowledge receipt of the Employer's First Notice of Injury. Please review the information provided to ensure accuracy. The claim number shown below should be used on all future correspondence and inquiries.

CASE MANAGER **DEBI BRUCE**

PHONE NUMBER **(510)945-4316**

CLAIM NUMBER 158 CB D5S2147 P	ASSIGNED BY SANDY STAUFFER	CUSTOMER SERVICE REP. TAP	NOTICE RECEIVED VIA TELE	BENEFIT STATE CA
---	--------------------------------------	-------------------------------------	------------------------------------	----------------------------

EMPLOYER INFORMATION

EMPLOYER'S NAME AND ADDRESS CIRCUIT CITY 1880 S GRANT ST SAN MATEO CA 94402-2648	RISK LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648	LOSS LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648
PARENT COMPANY NAME CIRCUIT CITY STORES, INC	SUBSIDIARY NAME CIRCUIT CITY	NATURE OF BUSINESS RETAIL ELECTRONICS STORES
LOCATION CODE: WS0232		POLICY TCSCSSC 240T0305

EMPLOYEE INFORMATION

EMPLOYEE'S NAME AND ADDRESS THOMAS GIBSON 66 ATHENS ST. SAN FRANCISCO CA 94112 PHONE: (415)584-7450	SOCIAL SECURITY NUMBER 547-56-2196	GENDER (M OR F) M	DATE OF BIRTH 11/14/43
MARITAL STATUS MARRIED		NUMBER OF DEPENDENTS 0	AGE

ACCIDENT / INCIDENT INFORMATION

DATE OF INJURY 07/01/96	TIME OF ACCIDENT	DATE REPORTED TO EMPLOYER 07/01/96	DATE NOTICE REPORTED 07/16/96	TIME NOTICE RECEIVED 03:53 PM	ACCIDENT ON EMPLOYER PREMISES? YES	COMPANY-SPONSORED EVENT? NO
LAST DATE WORKED		WAS EMPLOYEE PAID FOR DATE OF INJURY?		IS SALARY BEING CONTINUED?	LAST DATE EMPLOYEE WAS PAID	
EMPLOYEE BACK TO WORK? YES		IF YES, DATE RETURNED TO WORK 07/01/96		DATE DISABILITY BEGAN	DATE DISABILITY ENDED	FATAL? NO

DESCRIPTION OF ACCIDENT
REPETITIVE USE OF ARM WHILE WORKING IN WAREHOUSE CAUSED TENNIS ELBOW.

CONTRIBUTING FACTORS

EQUIPMENT, MATERIAL(S) OR SUBSTANCE(S) INVOLVED

SAFEGUARDS PROVIDED?

SAFEGUARDS IN USE?

WHAT SAFEGUARDS?

WITNESS INFORMATION
NAME (FIRST, M, LAST)

ADDRESS

PHONE NUMBER

OTHER PARTIES INVOLVED
NAME (FIRST, M, LAST)

ADDRESS

PHONE NUMBER

CONFIDENTIAL

NOVEMBER 8, 1996

11/15/96
New 1-2/26
4 of 6
3-3/21/97

This will acknowledge receipt of the Employer's First Notice of Injury. Please review the information provided to ensure accuracy. The claim number shown below should be used on all future correspondence and inquiries.

CASE MANAGER **CARLENE M HENDRICSON** PHONE NUMBER **(510)945-4308**
CLAIM NUMBER **158 CM D5S7537 M** ASSIGNED BY **CARLENE M HENDRICSON** CUSTOMER SERVICE REP. **CR** NOTICE RECEIVED VIA **TELE** BENEFIT STATE **CA**

EMPLOYER INFORMATION

EMPLOYER'S NAME AND ADDRESS CIRCUIT CITY 1880 S GRANT ST SAN MATEO CA 94402-2648	RISK LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648 LOCATION CODE: WS0232	LOSS LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648 POLICY TCSCSSC 240T0305
PARENT COMPANY NAME CIRCUIT CITY STORES, INC	SUBSIDIARY NAME CIRCUIT CITY	NATURE OF BUSINESS RETAIL ELECTRONICS STORES

EMPLOYEE INFORMATION

EMPLOYEE'S NAME AND ADDRESS THOMAS GIBSON 66 ATHENS SAN FRANCISCO CA 94112 PHONE: (415)584-7450	SOCIAL SECURITY NUMBER 547-56-2196	GENDER (M OR F) M	DATE OF BIRTH 11/14/43
	MARITAL STATUS MARRIED	NUMBER OF DEPENDENTS 0	AGE

ACCIDENT / INCIDENT INFORMATION

DATE OF INJURY 10/01/96	TIME OF ACCIDENT 04:45 PM	DATE REPORTED TO EMPLOYER 10/31/96	DATE NOTICE REPORTED 11/07/96	TIME NOTICE RECEIVED 06:44 PM	ACCIDENT ON EMPLOYER PREMISES? YES	COMPANY SPONSORED EVENT? NO
LAST DATE WORKED		WAS EMPLOYEE PAID FOR DATE OF INJURY?		IS SALARY BEING CONTINUED?		LAST DATE EMPLOYEE WAS PAID
EMPLOYEE BACK TO WORK? YES		IF YES, DATE RETURNED TO WORK 10/01/96		DATE DISABILITY BEGAN		DATE DISABILITY ENDED
DESCRIPTION OF ACCIDENT ASSOCIATE EXPERIENCED LEFT SHOULDER AND ARM PAIN WHILE WORKING.				FATAL? NO		IF YES, DATE OF DEATH

CONTRIBUTING FACTORS

EQUIPMENT, MATERIAL(S) OR SUBSTANCE(S) INVOLVED	SAFEGUARDS PROVIDED?	SAFEGUARDS IN USE?	WHAT SAFEGUARDS?
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WITNESS INFORMATION NAME (FIRST, M, LAST) 425 E. 2nd St. E. Jordan	ADDRESS 1261 E. HILLSDALE BL. #2 FOSTER CITY CA 94404	PHONE NUMBER 415-584-7450
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OTHER PARTIES INVOLVED NAME (FIRST, M, LAST)	ADDRESS	PHONE NUMBER
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DWC-1
5 of 6

CONSTITUTION STATE SERVICE COMPANY

CONFIDENTIAL

MARCH 14, 1997

RECEIVED

MAR 21 1997

RISK MGMT.

NU

This will acknowledge receipt of the Employer's First Notice of Injury. Please review the information provided to ensure accuracy. The claim number shown below should be used on all future correspondence and inquiries.

CASE MANAGER GAIL A HESECAR

PHONE NUMBER (510)945-4244

CLAIM NUMBER 158 CB D2W3212 E	ASSIGNED BY ANNE FORD	CUSTOMER SERVICE REP. KA	NOTICE RECEIVED VIA TELE	BENEFIT STATE CA
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EMPLOYER INFORMATION

EMPLOYER'S NAME AND ADDRESS CIRCUIT CITY 1880 S GRANT ST SAN MATEO CA 94402-2648	RISK LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648 LOCATION CODE: WS0232	LOSS LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648 POLICY TCSCSSC 240T0305 NATURE OF BUSINESS RETAIL ELECTRONICS STORES
PARENT COMPANY NAME CIRCUIT CITY STORES, INC	SUBSIDIARY NAME CIRCUIT CITY	

EMPLOYEE INFORMATION

EMPLOYEE'S NAME AND ADDRESS THOMAS H GIBSON 66 ATHENS STREET SAN FRANCISCO CA 94112 PHONE: (415)337-0629	SOCIAL SECURITY NUMBER 547-56-2196 MARITAL STATUS MARRIED	GENDER (M OR F) M NUMBER OF DEPENDENTS 0	DATE OF BIRTH 11/14/43 AGE
--	--	---	----------------------------------

ACCIDENT / INCIDENT INFORMATION

DATE OF INJURY 12/04/96	TIME OF ACCIDENT	DATE REPORTED TO EMPLOYER 12/04/96	DATE NOTICE REPORTED 03/13/97	TIME NOTICE RECEIVED 06:42 PM	ACCIDENT ON EMPLOYER PREMISES? YES	COMPANY-SPONSORED EVENT? NO
LAST DATE WORKED		WAS EMPLOYEE PAID FOR DATE OF INJURY?		IS SALARY BEING CONTINUED?		LAST DATE EMPLOYEE WAS PAID
EMPLOYEE BACK TO WORK? YES		IF YES, DATE RETURNED TO WORK 12/04/96		DATE DISABILITY BEGAN		DATE DISABILITY ENDED
FATAL? NO		IF YES, DATE OF DEATH				

DESCRIPTION OF ACCIDENT
EMPLOYEE HURT LEFT HIP MOVING MERCHANDISE.

CONTRIBUTING FACTORS

N

EQUIPMENT, MATERIAL(S) OR SUBSTANCE(S) INVOLVED

LIFTING ITEMS

WITNESS INFORMATION
NAME (FIRST, MI, LAST)

3254 12/04/96 - will get signed -
- Fred to me -

OTHER PARTIES INVOLVED
NAME (FIRST, MI, LAST)

ADDRESS

PHONE NUMBER

6 of 6

CONSTITUTION STATE SERVICE COMPANY

APRIL 7, 1998

This will acknowledge receipt of the Employer's First Notice of Injury. Please review the information provided to ensure accuracy. The claim number shown below should be used on all future correspondence and inquiries.

OFFICE PHONE NUMBER (510)945-4000

CLAIM NUMBER 158 BPH5688 J	ASSIGNED BY DAWN S BASS	CUSTOMER SERVICE REP. LH	NOTICE RECEIVED VIA TELE	BENEFIT STATE CA
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EMPLOYER INFORMATION

EMPLOYER'S NAME AND ADDRESS CIRCUIT CITY 1880 S GRANT ST SAN MATEO CA 94402-2648	RISK LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648 LOCATION CODE: WS0232	LOSS LOCATION 1880 S GRANT ST SAN MATEO CA 94402-2648 POLICY TCSCSSC 240T0305
PARENT COMPANY NAME CIRCUIT CITY STORES, INC	SUBSIDIARY NAME CIRCUIT CITY	NATURE OF BUSINESS RETAIL ELECTRONICS STORES

EMPLOYEE INFORMATION

EMPLOYEE'S NAME AND ADDRESS THOMAS H GIBSON 66 ATHENS SAN FRANCISCO CA 94112 PHONE: (415)584-7450	SOCIAL SECURITY NUMBER 547-56-2196	GENDER (M OR F) M	DATE OF BIRTH 11/14/43
	MARITAL STATUS SINGLE MARRIED	NUMBER OF DEPENDENTS 0	AGE

ACCIDENT / INCIDENT INFORMATION

DATE OF INJURY 03/12/97	TIME OF ACCIDENT	DATE REPORTED TO EMPLOYER 04/06/98	DATE NOTICE REPORTED 04/06/98	TIME NOTICE RECEIVED 05:57 PM	ACCIDENT ON EMPLOYER PREMISES? YES	COMPANY-SPONSORED EVENT? NO
LAST DATE WORKED		WAS EMPLOYEE PAID FOR DATE OF INJURY?		IS SALARY BEING CONTINUED?		LAST DATE EMPLOYEE WAS PAID
EMPLOYEE BACK TO WORK? YES	IF YES, DATE RETURNED TO WORK		DATE DISABILITY BEGAN	DATE DISABILITY ENDED	FATAL? NO	IF YES, DATE OF DEATH

DESCRIPTION OF ACCIDENT
EE HAD HURT HIS BACK AND KNEES PREVIOUSLY AND THE PROBLEM IS FLARING UP AGAIN.

CONTRIBUTING FACTORS

N

EQUIPMENT, MATERIAL(S) OR SUBSTANCE(S) INVOLVED	SAFEGUARDS PROVIDED? NO	SAFEGUARDS IN USE? NO	WHAT SAFEGUARDS?
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WITNESS INFORMATION NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER
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OTHER PARTIES INVOLVED NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER
--	---------	--------------

NEW LOCATION

Peter J. Mandell, M.D.

See Below:

A PROFESSIONAL CORPORATION
Orthopedist

November 29, 2000

Moiria L. Stagliano, Esq.
SCHMIT LAW OFFICE
456 Eighth Street
Oakland, CA 94607

TREATING PHYSICIAN PERMANENT AND STATIONARY REPORT

Re: Thomas GIBSON
WCAB No.: SFO 0402089, et al.
Claim No.: 158 CB D2W4967 J

Ladies and/or Gentlemen:

Mr. Thomas Gibson was seen in my office today.

In conjunction with this examination I reviewed my medical file. No additional medical records were available for review.

HISTORY OF INJURY:

It will be recalled that Mr. Gibson worked for Circuit City as a warehouseman. He did have specific injuries to his lower back in December of 1996. He also had an injury to his LEFT knee in March of 1997. Subsequently he saw Dr. Grove. He underwent surgery on his LEFT knee in about November of 1997. Mr. Gibson understands that a cartilage tear was treated at that time. Mr. Gibson got some relief for awhile. He was off work for a while and then went back to work, but he had recurring problems.

I started seeing Mr. Gibson in December of 1998. At that time, we tried him on physical therapy and medicine. Mr. Gibson tried to keep working. Eventually he went off work in about March of 1999. He hasn't worked since.

Re: Thomas GIBSON
November 29, 2000

Page 2 of 7

HISTORY OF INJURY (Cont'd):

Currently he is taking Neurontin from Dr. Slucky.

CURRENT COMPLAINTS:

He has almost constant lower back pain. The pain is mostly in the LEFT lower back. Sometimes the low back pops. The pain radiates down both lower extremities, LEFT greater than RIGHT. The pain goes down the posterior thigh to just above the LEFT knee. He has numbness and tingling across the top of his LEFT foot. He hasn't noticed any weakness in the leg.

He has constant LEFT knee pain. The LEFT knee back-knees a lot. He limps all the time. He doesn't use a cane anymore because that hurts his shoulder. He can't run or do any sports. He can't really squat or kneel. Just last Saturday he was fixing a flat tire. When he got up, his RIGHT knee started hurting. He has trouble going up and down stairs because of his knees.

He also has tingling in the LEFT upper extremity (he went to Kaiser about that, and they found out that he has degeneration in his neck). His RIGHT shoulder is bothering him since it got cold again.

He was asked multiple times; he recalls no other symptoms except as listed above.

INTERVAL PAST HISTORY:

Current medications include Neurontin, Paxil, and nortriptyline. Since I started seeing him in December of 1998, he has had no surgeries or hospitalizations.

LUMBAR SPINE:

Stated ht: 5'8"

Stated wt: 170 lbs.

Stated Age: 57

The patient states he is LEFT-handed.

The patient stands in good posture without trunk list. The physiologic lumbar lordosis is well preserved.

Re: Thomas GIBSON
November 29, 2000

Page 3 of 7

LUMBAR SPINE (Cont'd):

The patient wears no brace, corset or collar. There are no scars noted.

There is no paravertebral muscle spasm and no local tenderness over the spines, paraspinal muscles, sacroiliac joints, or sacrosclatic notches. The following ranges of active lumbar spinal motion are demonstrated by the patient:

Forward flexion:	Fingertips fail floor by 6 inches. The lumbar curve reverses.
Hyperextension:	33% of normal.
Lateral flexion to the right:	90% of normal.
Lateral flexion to the left:	90% of normal.

When the patient is asked to cough, no increased pain is noted. The percussion and jarring tests are negative. Straight-leg raising is 90/90 degrees bilaterally in the seated position and 70/80 degrees (Right/Left) in the recumbent position. The Lasegue and Bowstring tests are negative.

NEUROLOGICAL EXAMINATION:

Reflexes:

The reflexes of the quadriceps (knees) are 2 on the RIGHT and 1 on the LEFT.

The reflexes of the gastrosoleus (ankles) muscle are 1 on the RIGHT and 2 on the LEFT.

Motor Power:

There are no fasciculations or atrophy and no motor weakness of the toe dorsiflexors or peronei.

Sensory:

There is no sensory loss to pinpoint in the lower extremities in a nerve root pattern.

Re: Thomas GIBSON
November 29, 2000

Page 4 of 7

LOWER EXTREMITY EXAMINATION:

The comparative circumferential measurements of the lower extremities are as follows:

	RIGHT	LEFT
Thighs, 6" above patella:	20-1/8	19-3/4 inches
Calf, maximum girth:	14-3/8	14-3/8 inches
Knees:		
Mid-patella:	15-3/4	15-1/4 inches

The patient walks with a limp on the RIGHT. The patient removes a hinged custom knee brace from the LEFT knee for the examination. There are no palpable or visible deformities of the hips noted. There is no tenderness about the anterior capsule or trochanters. Patrick and Trendelenburg tests are negative. Hip range of motion is as follows:

		NORMAL :
Extension:	30/30	(30 degrees)
Flexion:	110/110	(110 degrees)
Internal rotation:	35/35	(35 degrees)
External rotation:	50/50	(50 degrees)
Abduction:	50/50	(50 degrees)
Adduction:	30/30	(30 degrees)

There is good gluteal strength.

KNEES:

There are no palpable or visible deformities of the knees noted. Squatting is 50% of normal with RIGHT knee pain. The kneeling maneuver is well performed. Hopping is painful on the RIGHT. There is 2+ knee fluid on the RIGHT. The patellae are not ballotable. There are LEFT knee scars. There is no knee tenderness. Ligament stability is within normal limits. Pivot shift test is normal. McMurray's and

Re: Thomas GIBSON
November 29, 2000

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KNEES (Cont'd):

Apley's tests are negative. There are no popliteal masses. There is no retropatellar crepitus. There is no knee pain. Active knee range of motion is as follows:

Extension:	0/-10	NORMAL (0 degrees)
Flexion:	110/140	(135 degrees)

LEGS-ANKLES-FEET:

There are no visible or palpable deformities noted. There is no ankle fluid. There is no ankle swelling. There is no tenderness about the ankle capsule, malleoli, collateral ligaments, or sinus tarsi. Ligament stability is within normal limits. Range of motion is as follows:

Dorsiflexion:	15/15	NORMAL (15 degrees)
Plantarflexion:	50/50	(50 degrees)
Inversion:	35/35	(35 degrees)
Eversion:	20/20	(20 degrees)

VASCULAR EXAMINATION:

Dorsalis pedis pulsations are intact on the LEFT. Posterior tibial pulsations are intact on the RIGHT. There is no elevation pallor, trophic changes, varices, edema, or dependent rubor.

X-RAYS:

None were submitted or ordered.

DISCUSSION:

Mr. Gibson's condition is now permanent, stationary, and ratable. He has a chronic lumbar sprain with lower extremity radiculopathy. This probably relates to cumulative trauma on his job as a warehouseman.

Re: Thomas GIBSON
November 29, 2000

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DISCUSSION (Cont'd):

The "specific" injuries are probably well documented cases of cumulative trauma. Factors of disability for the low back include:

1. Restrictions of spinal motion.
2. Restrictions of straight-leg raising.
3. Some depression of the LEFT knee jerk and RIGHT ankle jerk.
4. Subjective complaints as stated.

I would characterize his **spinal subjective complaints** as **constant and slight**, becoming **frequent slight to moderate**. For the **spine alone**, I would preclude him from **heavy lifting**.

From time to time he will have need of additional treatment, such as analgesic medication and physical therapy. Appropriate provision should be made for that.

For his **lower extremities**, his condition is also permanent, stationary, and ratable. His diagnosis is chronic knee sprains and the residuals of a LEFT knee arthroscopy (and probable meniscectomy). Factors of disability there include:

1. Restrictions of knee motion.
2. Subjective complaints as stated.

I would characterize his **lower extremity subjective complaints** as **constant slight to moderate**. For the **lower extremities alone**, I would preclude him from **heavy lifting, climbing, walking over uneven ground, squatting, kneeling, crouching, crawling, pivoting, and other activities involving comparable physical effort**. His lower extremity problems also related to cumulative trauma.

From time to time he will have need of additional treatment for his lower extremities, such as analgesic medication, physical therapy, or even more surgery, and provision should be made for that.

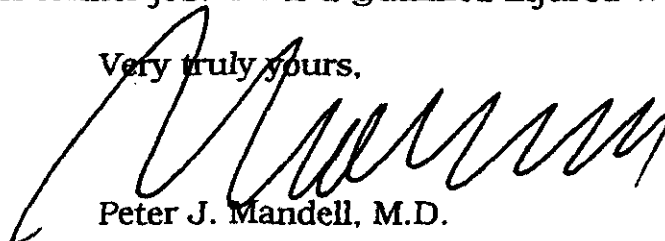
Re: Thomas GIBSON
November 29, 2000

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DISCUSSION (Cont'd):

He cannot return to his former job. He is a Qualified Injured Worker.

Very truly yours,

A handwritten signature in black ink, appearing to read "Peter J. Mandell", written over the typed name.

Peter J. Mandell, M.D.

PJM/ae

cc: CONSTITUTION STATE SERVICE COMPANY
ATTN: Lillian Peacock, Claims
P.O. Box 8112
Walnut Creek, CA 94596-8112

Fred L. Kurlander, Esq.
KURLANDER & BURTON
703 Market Street, #1600
San Francisco, CA 94103

SFMRC

MRI • OPEN MRI • PET

PATIENT: GIBSON, THOMAS

REFERRED BY: MARVIN LIPTON, MD

DOB: 11/14/1943

EXAM: MR RIGHT SHOULDER WITHOUT
CONTRAST

EXAM DATE: 06/05/2006

CLINICAL DATA: History of shoulder pain.

TECHNIQUE: Gradient echo axial, fast spin echo T2 axial, coronal T1 and fast spin echo T2 fat saturation, and sagittal fast spin echo T2 images were performed in a high field magnet. Exam is somewhat limited due to patient motion.

COMPARISON STUDY: None.

IMPRESSION:

1. MODERATE TO SEVERE ROTATOR CUFF TENDINOSIS WITH SUBACROMIAL/SUBDELTOID BURSITIS, BUT NO EVIDENCE FOR A FULL-THICKNESS TEAR OR RETRACTION. TERES MINOR MUSCLE ATROPHY IS SEEN.
2. SLAP LESION EXTENDS TO, BUT IS NOT AVULSED BY, THE BICEPS ANCHOR AND IS ASSOCIATED WITH POSTEROSUPERIOR PARALABRAL CYST EXTENDING TO THE SPINOGLENOID AND SUPRASCAPULAR NOTCH REGIONS.
3. GLENOHUMERAL DEGENERATIVE CHANGE.
4. SEVERE ACROMIOCLAVICULAR JOINT DEGENERATIVE CHANGE WITH DOWNSLOPING ACROMION AND POSTSURGICAL CHANGES.
5. SUBSCAPULARIS TENDINOSIS IS PRESENT.

FINDINGS:

OSSEOUS ACROMIAL OUTLET: A Type I acromion is noted with mild lateral downsloping and severe acromioclavicular joint degenerative change consistent of marrow edema, joint effusion, capsular hypertrophy and degenerative spurring. Postsurgical changes are seen as well.

1180 Post Street • San Francisco, CA 94109 • phone 415.563.3133 • fax 415.563.1506

SFMRC

MRI • OPEN MRI • PET

PATIENT: GIBSON, THOMAS

REFERRED BY: MARVIN LIPTON, MD

DOB: 11/14/1943

EXAM: MR RIGHT SHOULDER WITHOUT
CONTRAST

EXAM DATE: 06/05/2006

ROTATOR CUFF: Moderate to severe tendinosis is appreciated without evidence for tear, retraction or atrophy. Subacromial/subdeltoid bursitis is present. Teres minor atrophy is present.

LABRAL AND CAPSULAR STRUCTURES: The superior labrum is abnormal in signal intensity and configuration, extending to, but not avulsing, the biceps anchor with an associated posterosuperior paralabral cyst measuring approximately 5 mm. The paralabral cyst likely extends to the suprascapular notch and spinoglenoid notch on coronal image 6 with component there measuring closer to 8 mm.

OSSEOUS STRUCTURES: The glenohumeral degenerative spurring is seen and osseous cystic resorptive change is seen, presumably on a degenerative basis, posterolaterally.

BICEPS TENDON ANCHOR: Involved by SLAP lesion but not avulsed. Biceps tenosynovitis is present. The biceps tendon is seen in the bicipital groove. Subscapularis tendinosis is seen as well.

MISCELLANEOUS: Subacromial/subdeltoid bursitis is seen. Paralabral cyst likely extends to the suprascapular notch and spinoglenoid notch regions.

Thank you for referring this patient to SFMRC.

Sonja Moelleken, M.D.

SM/ln

D: 06/06/2006 09:45:53/T: 06/06/2006 10:51:19

Doc ID: 1576526/Voice ID: 1503976/4945550

Document authenticated by Sonja Moelleken, M.D., on 06/06/2006 11:18:02 PT

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Page 2 of 2

Please be advised that if a signature is not affixed to this document, via manual or electronic document authentication, the information contained herein should be considered preliminary in nature, still subject to change, and should not be relied upon.



PATIENT: GIBSON, THOMAS

REFERRED BY: MANDELL, PETER

DOB: 11/14/43

EXAM: MRI LUMBAR SPINE

EXAM DATE: 7/19/99

CLINICAL DATA: Low back pain off and on. Both hips are numb and lower left leg is numb. Slip at work in 12/97.

MRI TECHNIQUE: Three sequences were performed: T1 weighted sagittal, T2 weighted sagittal, proton density and T2 weighted axial sequences.

[Please note: If surgical therapy is contemplated, comparison with plain films for accurate vertebral body level count is recommended, as MRI is unable to accurately count vertebral body levels. In this study, the inferiormost complete intervertebral disc space is referred to as the L5-S1 level.]

COMPARISON STUDY: None.

IMPRESSION:

1. FINDINGS CONSISTENT WITH EITHER LEFT FAR LATERAL DISC HERNIATION CAUSING FOCAL SWELLING OF THE EXITED LEFT L4 NERVE AT THE L4-5 LEVEL VERSUS FORAMINAL NEUROMA. WE COULD CONSIDER ADMINISTERING GADOLINIUM TO THE PATIENT FOR FURTHER SPECIFICITY TO DETERMINE WHETHER THIS REPRESENTS A DISC HERNIATION OR A NEUROMA.
2. MILD DISC BULGE AT L3-4 LEADING TO MILD CENTRAL STENOSIS.
3. DEGENERATIVE CHANGES OF THE FACETS, L4-5 AND L5-S1.

FINDINGS:

Vertebral body alignment is within normal limits. A small Schmorl's node deforms the inferior end plate of T11. No evidence of acute vertebral body trauma. There are mild changes of spondylosis anteriorly at the L2-3 level and L4-5 level, consisting of mild anterior disc bulging and minimal osteophyte formation. The conus medullaris is normal in size, shape, signal intensity and position terminating at the T12-L1 level.

(CONTINUED)



PATIENT: GIBSON, THOMAS

REFERRED BY: MANDELL, PETER

DOB: 11/14/43

EXAM: MRI LUMBAR SPINE

EXAM DATE: 7/19/99

(CONTINUED - PAGE 2)

Findings at specific levels:

T12-L1 through L2-3: No disc or nerve abnormality is identified. Disc height and hydration is preserved. I see no evidence of bulge or protrusion. The nerves exit the foramina normally. No evidence of central canal, lateral recess or foraminal stenosis is seen.

L3-4: No evidence of disc dehydration or disc space narrowing, but there is a minimal disc bulge present leading to minimal effacement of the anterior thecal sac.

L4-5: There is asymmetry in the region of the exited L4 nerve roots bilaterally, seen best on image 31, sheet 3, and also on sagittal image 2, sheet 1. There is either a small lateral dissect herniation with resultant swelling of the nerve root or focal swelling, perhaps a neuroma on the left side. This is superimposed upon a mild disc bulge leading to mild central stenosis. Mild facet degenerative changes are present. The right foramen is patent.

L5-S1: Moderate disc deterioration. No evidence of disc bulge or herniation. There are mild degenerative changes of the facets.

Thank you for referring this patient to SFMRC.

PHILLIP TIRMAN, M.D.

HW

d: 7/19/99

t: 7/19/99

PATIENT	PROVIDER	CATEGORY	VIEW	FR DATE	TO DATE
00977630		RADIOLOGY	REPORT	/ /	/ /

Patient 1 of 1 Personal Physician : PETER A REMEDIOS,MD SF
GIBSON,THOMAS 57/M Radiology Report Exam 1 of
Page 1 of

SPINE CERVICAL 4+ VIEWS

Ordered By: REMEDIOS, PETER MD on 07/11/2000 10:11 at SFO OUTPATIENT

Performed In: SFO - Read By: FOO, GEORGE MD

** HISTORY **:

Degenerative joint disease.

** FINDINGS **:

Alignment appears normal. The C5-6 and C6-7 disc spaces are moderately severely narrowed. There is almost 50% bilateral encroachment at these two levels, slightly more severe at the C5-6 level.

G W FOO M.D.

RAD.REP

SFOP2R 11/08/00 11:19

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

Thomas Gibson

Applicant

Case No. SFO 0401189; 0401188;
0407360; 0407361;
0407362; 0402089

Stipulations

with Request

for Award

vs.
Circuit City, Const. Union States
Service Co.

Defendants

The parties hereto stipulate to the issuance of an Award and/or Order, based upon the following facts, and waive the requirements of Labor Code Section 5313:

1. Thomas Gibson (Employee), born 11/14/43, while employed within the State of California as warehouse man (Occupation) on 5/3/95; 7/1/96; 10/1/96; 12/10/96 (Date of Injury) by Circuit City (Employer) whose compensation insurance carrier was PSI, CSI sustained injury arising out of and in the course of employment bilateral (Parts of body injured) upper, lower extremities, back, lower extremities, SHOULDER.

2. The injury caused temporary disability for the period broken periods through _____ for which indemnity is payable at \$ 404.64 per week, less credit for such payments previously made. There are no claims for unpaid temporary disability.

3. The injury caused permanent disability of 62% %, for which indemnity is payable at \$ 170 per week beginning August, 2003 in the sum of \$ 62262.50, less credit for such payments previously made.

An informal rating has not been previously issued.
(Select one)

4. There is (Select one) need for medical treatment to cure or relieve from the effects of said injury.

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

5. Medical-legal expenses are payable by defendant as follows: Paid, adjusted or litigated by defendant.

6. Applicant's attorney request a fee of \$ 9300.00 ~~9300.00~~ TO BE DEDUCTED FROM FINAL AWARD.

7. Liens against compensation are payable as follows: Paid, adjusted or litigated by defendant.

8. Other stipulations: Interest is included if all sums due under Award are paid within 25 days of date of service of Award. Parties agree Stipulation resolves all claims for penalties under Labor Code Section 5814, 5814.5 and 4650, or any other Labor Code Section arising from date of injury through date of receipt of Award.

THE PERMANENT DISABILITY PAID HEREIN IS FOR LIFETIME DISABILITY AND SHOULD BE PAID OVER THE LIFE EXPECTANCY OF THE APPLICANT, WHICH IS 25.53 YEARS. OF THE FOREGOING PERMANENT DISABILITY \$2240.00 WAS PAID FOR THE PERIOD OF 4-11-72 TO 12-3-96, AND \$12,501.43 PAID AT \$150/WEEK FROM 11-4-94 TO 3-25-01. \$9300.00 OF THE DISABILITY IS PAID FOR ATTORNEY FEES.

3-29-01

Dated

X Thomas N. Gibson
Applicant

Thomas Gibson

547-56-2196

Social Security Number of Applicant

66 Athens Street

San Francisco, CA 94112

Address of Applicant

Mr. Fred L. Kurlander, Esq.
Attorney for Applicant

703 Market St., Suite 1600

Address of Attorney for Applicant

San Francisco, CA 94103

DWC WCAB FORM 3 (REV. 9-90)

Address of Employer

P.O. Box 8112

Walnut Creek, CA 94596

Address of Insurance Company

Moira L. Stagliano

Attorney or Authorized Representative for Defendant

Moira L. Stagliano, Esq.

456 8th Street

Address of Attorney or Authorized Representative

Oakland, CA 94607

WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

AWARD

AWARD IS MADE in favor of Thomas Gibson against
Circuit City Stores of:

(A) Temporary disability indemnity in accordance with paragraph 2 above,

(B) Permanent disability indemnity in accordance with paragraph 3 above,

Less the sum of \$ 9300.00 payable to applicant's attorney as the reasonable value of services rendered, *to be commuted from the far end of the award.*

Less liens in accordance with Paragraph 7 above.

(C) Further medical treatment in accordance with Paragraph 4 above,

(D) Reimbursement for medical-legal expenses in accordance with Paragraph 5 above,

(E)

March 29, 2001
Date:


Workers' Compensation Judge
WORKERS' COMPENSATION APPEALS BOARD

Notice to:

Maria Stagliano, et al

Pursuant to rule 10500, you are designated to serve the attached document(s) on all parties shown on the Official Address Record along with proof of service. You shall maintain proof of service, which shall not be filed with the WCAB unless a dispute arises regarding service of the document.

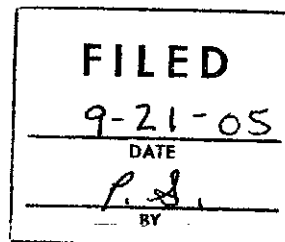
By: 

On: 3/29/01

(Signature)

WORKERS' COMPENSATION APPEALS BOARD
STATE OF CALIFORNIA

THOMAS GIBSON,)	CASE NOS.	SFO 401188
)	SFO 401189,	SFO 407361
Applicant,)	SFO 407362	
)		
vs.)	MINUTES OF HEARING	
)		
CIRCUIT CITY, adjusted by)		
HELMSMAN MANAGEMENT SERVICE INC.,)		
)		
Defendants.)		



PLACE and TIME: San Francisco - September 20, 2005 - 8:30 a.m.

JUDGE: SUSAN V. HAMILTON
REPORTER: Peggy Scavone

APPEARANCES: Applicant present, represented by Law Offices of Kurlander & Burton; Fred L. Kurlander, Esq. appearing.

Defendant St. Paul Traveler's represented by Neal A. Summers, Hearing Representative.

EXPEDITED HEARING - NO TESTIMONY TAKEN

JUDGE: I will note that the underlying Board files which date back quite a few years have, unfortunately, been destroyed. Mr. Summers has clarified that his client, St. Paul Traveler's, is the responsible Defendant in these cases which were resolved some years ago by a stipulated award that entitled Applicant to further medical treatment. We had off record discussions concerning foremost the fact that the Board files, unfortunately, were destroyed some years ago and not available for my review.

(NOTE: Minutes continue on following pages.)

DISPOSITION: Mr. Kurlander has 30 days to submit Points and Authorities and documentation in support of his request, and Mr. Summers has 20 days thereafter to respond at which point the issue of an attorney's fee will be submitted for decision.

SFO 401188, et al. GIBSON SEPTEMBER 20, 2005 PAGE 2

Second, that the Board file that has been reconstructed is inadequate in that it does not have the original AME report from Dr. Lipton nor all of the current reports of the treating physician and the utilization review physicians.

The dispute does appear to be chiropractic treatment that was prescribed that was then subjected to a utilization review process. And based upon that utilization review, Defendant denied the treatment.

Mr. Summers has pointed out that Applicant was treating with Dr. Zinner, a chiropractor, and has also treated with Dr. Mandell. Treatment is no longer active with Dr. Zinner.

Counsel were able to reach a resolution of some of the disputed issues. They have agreed that Dr. Mandell remains the treating physician, and Defendant has agreed to authorize Applicant to be seen by the chiropractor in Dr. Mandell's office for that chiropractor to formulate a recommended treatment plan. Further, the parties have agreed to go to Dr. Lipton as the AME. Dr. Lipton will help address medical treatment issues.

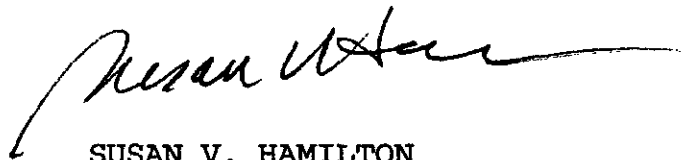
This case is beyond the time period within which a Petition to Reopen could be filed. So what remains outstanding are medical treatment issues. I'm satisfied that the plan presented is a very intelligent agreement that will help lead to a resolution of the disputed issues.

Mr. Kurlander has requested an attorney's fee for his services in assisting Mr. Gibson with enforcement of the outstanding medical award. He makes that request under Labor Code Section 4607. In off record discussions, I advised the parties that I did not feel that I had sufficient information to determine such issue. In my understanding of Labor Code Section 4607 and the case law that have further interpreted that section, I will need to determine whether or not Defendant's conduct was such that it could be the equivalent of a petition to terminate medical treatment. I understand that there was a utilization review process, and I will need to determine the chronology of medical treatment requests and response thereto in order to determine whether an attorney's fee at the expense of Defendant would be appropriate in this case.

SFO 401188, et al. GIBSON SEPTEMBER 20, 2005 PAGE 3

I do acknowledge that Mr. Kurlander has had to assume this responsibility, and that the work required is somewhat more than in simply representing the Applicant in a current case. The Board files are not available for his review, and he has had to obtain whatever information he needed from his own archived files and from other information provided by Defendant.

I will allow Mr. Kurlander an opportunity to submit in writing his request for an attorney's fee, and I will provide Mr. Summers with an opportunity to respond. And, otherwise, all other disputed issues are the product of an amicable at least interpreted resolution. So those issues will remain off calendar.



SUSAN V. HAMILTON
WORKERS' COMPENSATION JUDGE

SVH/ps